DASIS STATE DATA ADVISORY GROUP MEETING
April 3-4, 2001
Portland, Oregon

Summary
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This meeting is the first of a second round of regional meetings being held with State DASIS Representatives. This meeting included representatives from Alaska, California, Hawaii, Nevada, Oregon, and Washington along with staff from the SAMHSA Office of Applied Studies, Mathematica for Policy Research, and Synectics for Management Decisions.

Opening and Overview

Dr. Donald Goldstone of the Office of Applied Studies (OAS) gave the opening remarks. He emphasized the importance of these face-to-face meetings between OAS staff and the State people who produce the data. The one-and-a-half-day meetings provide a forum for OAS staff to inform the States about current activities and to give States an opportunity to share with OAS and each other their solutions to common problems in data collection and management of information.

Dr. Goldstone stressed the importance OAS attaches to State feedback from these meetings and the importance previous comments have already played in developing the N-SSATS questionnaire, modifying the I-SATS On-line, and in the analysis and presentation of the DASIS data.

For example, dataset names were changed because of comments at the Charleston meeting. Many State representatives had been recently assigned to DASIS and found that the old names (UFDS, NMFI) did not describe what was involved in the project. At the same meeting, there were complaints that representatives were given the DASIS project but not directions on what to do. In response, OAS has produced a brochure about the project and what is expected of DASIS representatives.

Dr. Goldstone emphasized that the meeting was a chance to have a discussion -- what are we doing right or wrong?-- so the schedule was flexible. He then summarized the agenda. First there would be a demonstration of the Facility Locator, then a discussion of the N-SSATS (the annual facility survey), followed by a discussion of the I-SATS (a master list of all facilities).

The next item would be something new. Based on comments received at the last meeting, OAS was introducing a segment devoted to short presentations by each of the States attending the meeting. The final item for Tuesday would be a presentation on the Health Insurance Portability and Accountability Act (HIPAA) in the context of DASIS since OAS has received many questions about it. What is it? What should it do? Where does it stand? Dr. Judy Ball, an OAS staff person, would give the HIPAA presentation. Items on Wednesday's agenda would include a discussion of TEDS and a demonstration SAMDA Online, a system for producing tables on line. Neither the Locator nor the data archive was operating at the last meeting of this group. The final items would be a discussion of the DAWN system redesign, followed by an update on the National Household Survey on Drug Abuse (NHSDA).

Demonstration of National Directory Facility Locator
Synectics has developed a system that displays the National Directory on the Web, allows users to query the directory for substance abuse providers, and shows provider locations on a map. The Locator has its own Web site address http://findtreatment.samhsa.gov. It became operational in November 1999. Since then, the hits on the Locator have gone from approximately 600 a week to 2,500 a week. Family members, substance abuse programs, individuals seeking treatment, and professionals who do referrals all use the Locator. The listings include only state-approved facilities, and the information is based on the facilities' answers to the 1999 N-SSATS survey.

Deborah Trunzo of OAS demonstrated the Locator's three search features. Users can do a quick search, a detailed search, or a list search. In the quick search, the user clicks on a State on a map, then enters a starting point (a street address, city, or zip code). The system searches the file for the substance abuse facilities closest to the starting point. It displays the results on a map and also generates a list with all the current directory information. The search area is a radius of 99 miles from the starting point. Users can also use the detailed search, which allows users to specify several of the directory variables as an aid in focusing the search. An example of a detailed search is: list all the providers in and around Portland, Oregon that are in a residential setting, have a treatment program for dually diagnosed clients, and take private insurance.

The third feature allows users to generate a list of facilities for a geo-political area using search capabilities similar to the detailed search. The list contains all the treatment facilities meeting the criteria for a geographic area. The area of the search can be one or more zip codes, cities, States, or the entire United States. Users can also use this feature to search for a facility by name (or part of a name).

Many of the States attending have used the system and find it useful. Some States have added a link from their site to the Locator.

The 2000 N-SSATS
Geraldine Mooney of Mathematica for Policy Research (MPR) provided handouts showing the response rates for the 2000 N-SSATS currently in the field. The response rate for the U.S. for State-approved facilities was approximately 90% and for non-State approved was 80% as of the end of March. The response rates for the States attending was between 84% and 95% for State-approved and between 65% and 87% for non-State approved.

Geri also discussed questionnaire changes pretested in the 1999 N-SSATS that were later incorporated into the 2000 survey. This included both adding and deleting questions. New questions included items that addressed: primary focus, separate intake telephone number, website address, accreditation, the availability of a sliding fee scale and other payment assistance, and a question on the provision of substance abuse treatment in languages other than English. Handouts of new questions and their results from 1999 survey were presented and discussed.

One question of particular interest pertained to how facilities define "intensive" outpatient care. Each year facilities are asked if they provide intensive outpatient, which is defined in our surveys as a minimum of 6 hours a week. The definition varies in the field; for example, the American Society of Addiction Medicine (ASAM) advocates a minimum of 9 hours a week. In 1999, facilities were asked for their definition of intensive outpatient. In the United States, 17% of the facilities defined intensive care as between 1 and 5 hours of outpatient care a week. Altogether, 31% reported intensive outpatient care constituted less than 9 hours a week. The States at the meeting varied from 46% of the facilities

reporting less than 9 hours to a low of 15 %. The distinction between outpatient and intensive outpatient varies greatly and leads to the conclusion that the category is without meaning.

The percent of facilities reporting offering a sliding scale greatly varied among the attending States -- between 22% to 80% of places.   The percent of facilities reporting offering subsidized care to some or all of their clients was between 69% and 90% of places.

Some longstanding N-SSATS questions were deleted because of the difficulties some facilities had providing the requested information, resulting in data of questionable quality.   The deleted items included: facility setting, detailed list of services, revenue, and counts of clients by sex, race, and age.

The next N-SSATS will have a new point prevalence date of March 29 instead of the current October 1. This change has been made to avoid having the survey in the field during the Thanksgiving -Christmas period. Based on comments received from the States, it was suggested that the point prevalence date coincide with an end of a quarter rather than the beginning of a month. The survey will begin with the mailing of advanced letters on February 11, 2002 and data collection will end September 27, 2002. The results for State review will be available in mid-December.

Karen Redman mentioned that there may be a problem with this time schedule since some follow-up work will take place during summer months when school-based programs are closed.

Updating the I-SATS
The I-SATS is a listing of all substance abuse providers in the country. Keeping this listing current and accurate is important. Information from the N-SSATS combined with the latest information on approved facilities from each State provides the data needed to produce the National Directory and the Facility Locator. The information from the States on State approval is critical to the validity of these listings.

In order to lessen the burden on States, OAS and Synectics are advocating the use of the I-SATS On-line system to update the I-SATS. In addition, Synectics is now sending out lists to the States to review on a flow basis, thereby spreading out the State burden over the year, because many States reported that reviewing comprehensive lists once a year was a very labor-intensive job. Rapid turnaround of these lists is important in maintaining the integrity of the Facility Locator and the I-SATS file.

Demonstration of New Feature for I-SATS
Up to now States have been unable to search I-SATS or to download all the facilities in their States by selected characteristics. Synectics staff demonstrated a new capability that will allow a State person to search I-SATS by city, county, or facility name. In addition, facilities can be selected based on status (active, non-active) state approval (approved, not approved) and whether or not they are a TEDS reporter. Results of all the searches can be downloaded to an Excel file or a text file (tab or comma delimited). Access to the system will be limited to people within a State who have a password for the I-SATS On-line system.

The States attending this meeting thought the system would be useful but requested a couple of additions. One is to add the search criteria of treatment versus non-treatment and the other is to add a link between I-SATS On-line and the query system. As soon as these changes are made, Synectics will notify each of the States attending and ask them to briefly test the system. Shortly thereafter it will be available to all authorized State personnel.

Another comment received was related to the I-SATS On-line system. The form on the system has a check box already marked "none" in the line requesting a fax number. When users enter a fax number, the system returns an error message and the "none" box stays checked. Synectics will correct this.

State Presentations
Washington--Fritz Wrede discussed Washington's efforts to implement a digital signature process as part of its implementation of a central Internet database system. Washington has an electronic commerce law that sets out requirements and procedures for digital certificates to allow for electronic signature of documents. These procedures will be used to authenticate users of the new reporting system. Digital Signature Trust in Salt Lake City will manage the State certificates. Over 320 agencies will use the system and each agency will have two certificates. Early in the process providers showed concern over the system's security, but this concern has been abated through ongoing involvement in the development of the system. Data will be encrypted throughout, and certificates will ensure the validity of transmissions. Currently the focus is on training their people about the need for a local firewall separate from the data being collected.

Oregon--Ben Kahn and Janelle Jegglie
Ben and Janelle talked about the errors involved in collecting TEDS data and Oregon's efforts to resolve them. Oregon has about 200 providers who submit TEDS data. The State contracts with counties, who subcontract to providers. TEDS data are collected at enrollment and discharge. (This in itself is a problem for methadone maintenance clients because Oregon may have no interim data for several years.) Oregon processes about 12,000 forms per month with two people entering the data into a mainframe.

Some of the errors involved in collecting TEDS data arise from the design of the paper form. The data form is multi-layer, with both enrollment and termination forms connected. The highlighted part should be filled out first, and then the form should be separated into enrollment and termination. This leads to problems, including the 4th copy being illegible. Oregon has reviewed this process and developed a list of the 10 most common problems arising from use of the form. In addition to the problem described above, others include total arrests being less than DUI arrests, termination forms arriving before enrollment forms, and beginning date of treatment being confused with client birth date. Errors found are brought to the attention of the providers, but it is sometimes difficult to get them to correct the errors.

At this point Janelle and Ben asked the Attendees what they do to get accurate data.
- Alaska's response was that a few years ago it tied submission of data to funding. Nevada and Washington have done the same, and it has improved reporting.
- Washington also publishes a listing of problem agencies, including a list of the 10 worst, in an effort to discourage poor reporting.
- California has chosen automation as the solution, but has run into problems with the Access-based platform because it won't run on Microsoft 2000.

Currently in Oregon 60% of the forms submitted have errors. These forms are either mailed back or errors are resolved over the phone, by fax, or email. When Oregon conducts a training, the rate drops to 30%, but when Oregon stops training the rate goes up. As a solution to the paper form problem, Oregon is beginning to introduce an automated system. Thirty-five of the 200 providers are doing electronic data collection.

Nevada--Jim Gibbs
The Client Data System in Nevada is an outdated data system. It's DOS-based, using Windows 98.

Providers don't get funding unless they send in data. The State provides technical support and retraining. The main plus of the system is the quality of Nevada's field personnel, who help to improve the data quality.

Nevada has used the data in several ways to influence or track changes in policy and/or treatment. For example, if you compare admissions by service type to funding, you find that the trends in admissions track the money flow. From this information Nevada has concluded that it lacks sufficient capacity to treat all those in need. In 1997, the legislation addressed adolescent admissions. Money was earmarked for adolescent treatment, and there has been an increase in the number of adolescents under treatment. Data about the number of pregnant/postpartum women admitted to treatment is provided to the Health Divisions Perinatal Substance Abuse Prevention Coordinator who sits on a commission that considers women's health issues.

Data raise questions; they cause people to think about an issue. The legislative Council Bureau Audit Division was critical of the Bureau's lack of documentation about priority population admissions (i.e., pregnant, DUI). Nevada put in place a system that tracks any priority population persons not admitted or given interim services within 48 hours. Currently, priority populations have 1.8 days to receipt of some services and 28.9 days for treatment, and non-priority populations have 38.9 days to treatment. If admissions are not being treated with priority, providers are contacted for placement referral.

Hawaii--Virginia Jackson
Hawaii has recently introduced an automated purchase-of-service system in which data and billings are tied together. This replaces an older system in which providers used paper and pencil and sent completed data forms to the Alcohol and Drug Abuse Division (ADAD) for verification and data entry. The system now uses a Windows operating system, an Access-based integrated system. The system automates and integrates contract monitoring, invoicing, and the collection of TEDS data. Providers send data to ADAD by disk on e-mail. Hawaii uses a unique client identifier consisting of DOB, initials, and 1 and 2 for male/female; therefore, clients can be tracked throughout the system. Hawaii also reports outcomes at discharge and 6-month follow-up.

Training is a continuing activity because the system is complex and providers are not necessarily data types, and there is a lot of turnover. Therefore, the addition of automated error identification and correction at the input stage, which would greatly improve the quality and timeliness of the data, is high on the list of priorities for enhancements. But, if the system is expanded, providers will need better computers than they currently have.

In answer to a question, Hawaii uses three different methods to reach the client for the 6-month follow-up, including personal contact, phone, and letter. Hawaii has one of the largest groups of mixed ancestry. In the 2000 census, 21% of Hawaii's population is of mixed ancestry, compared to 7% of the U.S. population. People report the ethnicity with which they identify.

Alaska--Paul Kaiser
Alaska needs to revise its system, and has begun to search for resources to support this effort. It is using an old system that is DOS-based, and it ships diskettes. Alaska is trying to consolidate reporting systems at the State level, but it has gradually increasing problems in being able to maintain the old system, and there is high turnover. Moreover, many providers are getting 3rd party software for their own accounting and case management systems, but are still having to enter data in the old system, which doesn't return anything. Alaska is trying to figure how to interface providers' systems with its own. It is also integrating with mental health data to take advantage of the new Medicaid system being developed,

but it's at the beginning of the concept phase.

Alaska currently gets data electronically from 40 sites, but most of the data are submitted on diskette. A continuing problem is the diversity of funding for substance abuse in the State. Funding comes from the Indian Health Service, regional health corporations, and the Departments of Corrections and Transportation. There are more special programs for youth and senior services, handled by different divisions with no systems to use or even feed into. Although the bulk of funding is from the State/Federal Block Grant, different divisions within the government make pitches for special blocks of these funds. All of these factors contribute to the difficulty of collecting data on all of the clients receiving substance abuse treatment.

All of this shows the need to develop a statewide system that will integrate data from several departments. Unfortunately there is little support for data collection. Everyone sees it as the other program's problem.

In the discussion that followed it was pointed out that there is a 5% set-aside from the Block grant that can be used for data system infrastructure, but that it usually is not used that way--there is always a struggle between money for services and money for analysis. Having a State director interested in data is very important.

California--Karen Redman
The California presentation described efforts to develop an integrated State database. Three years ago, the new State information officer had a vision of one integrated central data repository. California launched the Enterprise Data Study to determine what data were needed and to draw a logical data module and relational database. The model included data on clients, funds, providers, services, and community. Central to an integrated system is a common agreement on who is a provider. Is a provider a legal entity, a site, a license, a program (collection of services)? The answer depends on whom you ask. It can refer to licensing, contracting, auditing, etc. In California, there are 13 master provider files all on different platforms with different structures and similar data. There is lots of duplication. California put these all together into a legal entity management system (LEMS). The legal entity may or may not be licensed, and provides programs/services at a site. The design and building of the system is nearly completed, but the details are still being finished off. One of the most difficult parts has been cleaning up of the various existing databases and verifying their data.

Health Insurance Portability and Accountability Act
Dr. Judy Ball of OAS gave a presentation on the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implications for data collectors. The purpose of the Act was to improve the efficiency and effectiveness of the health care system by establishing standards for the electronic exchange of certain administrative and financial transactions and to ensure the security and privacy of health information. The Act applies to all health plans, all health care clearinghouses, and all health care providers that elect to conduct transactions electronically. HIPAA has three major elements: transactions and code sets; identifiers; and security and privacy protections.

The first element is the transaction code set standards. HIPAA requires the adoption of national standards for efficient electronic administrative and financial transactions. The proposed rule for transaction and code set standards was published May 7, 1998, and the final rule was published August 17, 2000. The compliance date was set for October 16, 2002 (October 16, 2003, for small health plans).

The second element concerns identifier standards. HIPAA requires the adoption of standard identifiers (National Provider Identifier ? NPI) for health care providers, employers, health plans, and individuals. The proposed NPI will be assigned to every health care provider (individuals and facilities); it will be a lifetime number, have no embedded intelligence, and will replace the multitude of identifiers currently assigned by health plans.

The third element is the Health Information Security and Privacy Standards. HIPAA requires the adoption of security standards to protect health information. The proposed security standards should be flexible; have technology-neutral guidelines and policies; have reasonable and appropriate administrative, technical, and physical safeguards to ensure the integrity and confidentiality of information, protect against threats or hazards, and prevent unauthorized uses or disclosures; and employ a digital signature standard.

HHS published the Final Rule on privacy regulations December 28, 2000. In February 2001, HHS extended the effective date of Final Rule, shifted the compliance date to April 14, 2003 (2004 for small health plans), and requested additional comments on the Final Rule. The comment period ended March 30, 2001.

The privacy standards apply to individually identifiable health information held or disclosed by a covered entity in any form (electronic or paper). Covered entities are health plans, health care clearinghouses, and health care providers that transmit any health information in electronic form in connection with an HIPAA transaction. The standards also cover contractors and agents of covered entities. A covered entity may use or disclose protected health information for research provided that an Institutional Review Board (IRB) or privacy board approves a waiver of individual authorization and the decision is consistent with waiver criteria.

Information can be used for research, provided that the personal identifiers have been removed so that the remaining information cannot be used alone or in combination to identify an individual. In general, dates of birth and/or of specific health events are not permitted. An alternative solution is to have a disclosure analysis done by a person with knowledge and experience with appropriate statistical methodology.

Demonstration of Online Data Analysis System
The Substance Abuse and Mental Health Data Archive (SAMHDA) goal is to provide researchers, academics, policymakers, service providers, and others with ready access to substance abuse and mental health data. Data and documentation can be downloaded from the Internet (http://www.icpsr.umich.edu/SAMHDA/index.html). Data sets are in SAS and SPSS format, and documentation is in PDF format.

The system uses a Data Analysis System (DAS) developed by the University of California at Berkeley. DAS was developed specifically for use on the Internet. It computes frequencies, cross tabulations, means, and correlations, and permits construction of subsets. Customized data sets and codebooks can be downloaded. The documentation includes a title page, cookbook notes, weighting information, bibliographic citation and data disclaimer, and description of imputations, data anomalies, and data problems.

Among the data sets available are the Treatment Episode Data Set (TEDS), the National Household Survey on Drug Abuse (NHSDA), and data from the Drug Abuse Warning Network (DAWN).

The demonstration focused on the TEDS data. The system allows the user to generate a query and build a table to answer the query on line. In order to protect confidentiality, the TEDS data undergoes a disclosure analysis. However, unlike the past public use file, this file includes the complete file rather than a one in four sample of the original file. Other recent changes include color coding of cells in cross tabs to indicate statistical significance. Other statistical analysis improvements include the addition of multiple regressions and comparisons of correlations.

In addition, OAS is creating a series of short reports focusing on a single issue. These reports will be developed using household, DAWN, and TEDS data. Plans call for issuing two reports a month.

It was suggested by Ben Kahn of Oregon that OAS consider placing the reports on the Internet and sending an e-mail to a distribution list. This type of distribution has been very successful in Oregon.

Redesign of DAWN
The Drug Abuse Warning Network (DAWN) data collection system is in the midst of an evaluation and subsequent redesign. The system will focus on monitoring patterns of drug use, tracking drug-related illness, and detecting new drugs. Talking to the users of the information was part of the evaluation. Currently the system is made up of a representative sample of short-term, non-federal general hospitals and a non-representative group of medical examiners that represent 139 jurisdictions and 40 metropolitan areas.

The strategy that emerged from the review was to replace the paper system with a web-based data entry system and provide even more timely feedback. Currently, 57 medical examiners are reporting in the new system. A system for emergency rooms will begin beta testing in May. Other changes were to simplify case selection, expand case definition, and include additional data elements on drug abuse, adverse events, presenting problems, and disposition.

The sample of emergency rooms will be expanded to provide more precise material estimates and expand the number of metro area estimates.

Analysis of National TEDS Data
Dr. Leigh Henderson of Synectics gave a slide presentation demonstrating some of the uses of Treatment Episode Data Set (TEDS) data at the national level. These featured U.S. trend maps for 1992? 1998 for heroin, amphetamines, and marijuana admissions. Also featured were density plots of age versus duration of use for first-time admissions to treatment for injected and inhaled heroin.

To introduce issues surrounding TEDS quality control, she diagrammed the relationships among the I-SATS, TEDS, and N-SSATS, and how these have changed over time. When the TEDS system was originally conceived, all data for the I-SATS, TEDS, and N-SSATS were received from the States. There was a requirement that both TEDS and N-SSATS be reported at the same level. This made it possible, based on the relationship between TEDS admissions and the N-SSATS census, to estimate the number of admissions in facilities that were not required to report TEDS data. However, the steps taken to ensure a more complete inventory--centralized administration of the N-SSATS, extensive efforts to identify facility networks and enumerate sites, and the I-SATS augmentation efforts--have meant that the connection between TEDS and N-SSATS is no longer clearly defined. States were asked if they could recommend ways to identify "networks" of facilities reporting TEDS data, and to indicate these on the I-SATS.

Review of Quality of TEDS Data
Treatment Episode Data Set (TEDS) data are being used more and more at the national level and as a result the coverage and quality of TEDS data are receiving more attention. Therefore OAS is undertaking an extensive review of all the TEDS data that has been submitted since 1993. Two tables were sent to all States attending the meeting. The first shows the number of admissions, transfers, and co-dependents submitted on a year-by-year basis. The second shows the distribution of all TEDS admissions by year and category. Similar tables will be sent to the remaining States throughout the next year. States will be asked to review these data and explain the problems. The reports appear to be effective in identifying data problems. Once the reason for the anomaly has been identified, the data will either be corrected or the deficiency will be documented. Ultimately this information will be available to users and will aid in the proper analysis of the data.

Current year data are also being examined more closely. Quarterly feedback tables have been instituted to monitor current year data. Ultimately, each State submission will pass through this type of QC process, which will enable OAS to identify problems while it is still possible to correct the data.

A discussion ensued about the requirements for reporting TEDS data and about the strengthened privacy laws that recently were passed for SAMHSA. The reporting requirements accompanying the block grant specify that States should report all substance abuse clients regardless of whether or not the provider or the client receives block grant funding. Many States have the mistaken understanding that only funded clients are to be reported to TEDS. The States attending suggested that OAS send each State the citation and text of this reporting requirement as well as the strengthened privacy law.

Update on NHSDA
Last August national and state estimates from the 1999 National Household Survey on Drug Abuse were released. This was the first time state estimates were available. The national estimate of illicit drug use was 14.8 million individuals.

State estimates were produced using a combination of direct estimate methods along with a regression estimate. The estimates are based on seven measures. Each year's sample is additive so over time the effect of the regression estimate on the state estimate is reduced.

Enhancements to the household survey include the addition of mental health data, and the sampling of urine and hair to test the validity of respondents' answers. It has also been proposed to select a sample of 6,000 youths between the ages of 9 and 11 and follow them through to the age of 25.

The household data are an extraordinarily valuable data set: the State data will be made available as soon as there are sufficient numbers for each State, and when the privacy problems have been worked out. OAS is investigating the possibility of using a licensing arrangement to facilitate the use of the data.

Closing Remarks
Dr. Goldstone ended the meeting by thanking the participants for their participation and urging them to feel free to contact OAS staff with any suggestions or problems they may have. He reiterated that the feedback OAS receives proves very useful and hoped that the State representatives find the exchange equally beneficial. Dr. Goldstone reiterated the importance of the partnership with the States and how important they are to the proper operation of the DASIS system.

AGENDA
DASIS REGIONAL MEETING
Alaska, California, Hawaii, Nevada, Oregon, Washington

April 3-4, 2001
Portland, Oregon

Tuesday

8:30 a.m.	Continental Breakfast
9:00 a.m.	Welcome and Introduction ……………………………………*Donald Goldstone, OAS*
9:15 a.m.	Demonstration of Substance Abuse Treatment Facility Locator . *Deborah Trunzo, OAS*
9:45 a.m.	National Survey of Substance Abuse Treatment Services……….*Geri Mooney, MPR*

- Status of 2000 N-SSATS survey
- Web questionnaire experience
- New items in 2000

11:00 a.m.	BREAK
11:15 a.m.	Inventory of Substance Abuse Treatment Services ………. *Peter Hurley, Synectics*

- Demonstration of web-based I-SATS applications
- The I-SATS and State licensing/approval practices

12:00 p.m.	LUNCH
1:00 p.m.	State Presentations ……………………………………….. S*tate participants*
2:30 p.m.	BREAK
2:45 p.m.	Health Insurance Portability and Accountability Act................................*Judy Ball, OAS*

- Privacy regulation
- National Provider Identifier

4:45 p.m.	Adjourn

Wednesday

8:30 a.m.	Continental Breakfast
9:00 a.m.	Treatment Episode Data Set

- Importance of the data ………………………………. *Donald Goldstone, OAS*
- TEDS analysis ……………………………………… *Leigh Henderson, Synectics*
- TEDS Improvement Program ……………………….. *Peter Hurley, Synectics*
- Data submission and quality control process …………. *Jim DeLozier, Synectics*

10:00 a.m.	Demonstration of the SAMHDA On-Line Data Analysis System ..*Charlene Lewis, OAS*
10:30 a.m.	BREAK
10:45 a.m.	National Household Survey on Drug Abuse ....*Donald Goldstone, OAS*
12:30 p.m.	Adjourn

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DASIS Regional Meeting
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April 3 & 4, 2001

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